801. Reference question/answer #91 and RFP Section L-11.c, page 80
This question was submitted regarding delivery of the "Organizational Structure" fifteen calendar days prior to submission of the Technical Proposal. The Government response stated, "A word document attached to an email to the Contracting Officer listing the prime contractor and major first tier subcontractors to include the addresses and telephone numbers each is sufficient.

a. Will the Government incorporate appropriate Q&A's into an RFP Amendment?

RESPONSE: The Government will not incorporate questions and answers into the RFP by Amendment. However, the Government will amend the RFP when the Government responds to a question with a statement that the RFP will be amended. In this case, the Government does not intend to amend the RFP based on the answer. In the absence of specific instructions in the RFP, then the Government is not requiring how the organizational structure must be submitted. The response to the referenced question was an example of an alternative.

b. Please explain how the offeror should expect to receive a reply to ensure receipt of the Organizational Structure.

RESPONSE: Potential offerors should not expect to receive a reply from the Government.

802. We understand that healthcare dollars for Tricare Overseas eligibles are not to be included in target underwritten healthcare costs. Does this also include the Puerto Rican eligibles? In other words, should healthcare dollars related to Puerto Rican eligibles be included in targeted underwritten healthcare costs?

RESPONSE: Puerto Rican eligibles are not part of the underwritten population.

803. Concerning TNEX Question and response 623 - Where are NAS requirements stated for a) 40 mile catchment areas (MTF), b) 200 mile catchment areas (regional), c) national catchment areas (STS). A search of TOM and TPM for STS and specialized treatment does not provide guidance. TOM Chapter 20, Section 2 only talks about exemptions from the STS requirements.

> **RESPONSE:** ***revised 20 September 2002***
>
> **RESPONSE:** Inpatient NAS requirements for the 40-mile catchment areas are stated in TPM, Chapter 1, Sec. 6.1. Since the STS program will be terminated on May 31, 2003, there should be no references to STS NAS for 200-mile or national catchment areas in the TNEX manuals. A future amendment will delete the STS reference in TOM, Chapter 20, Sec. 2.

Does "terminated" imply that the MTF no longer have the capacity to provide these services?

RESPONSE: The STS program is being terminated. Currently, there are no plans to reduce the capacity of the facilities providing these services just because the STS program ends. However, other events separate from the STS termination may affect the capacities.

804. These questions relate to the detailed direct care ambulatory encounter files on the data tapes. In these files, each record appears to have fields for one E&M (Evaluation and Management) code (required), plus up to four other procedure codes.

a. If a patient encounter generates more procedure codes that would fit on one record, what happens to the extra codes?

RESPONSE: The additional procedure codes are captured locally but not forwarded to the MHS Data Repository.

b. Is a second encounter record generated, presumably including the same E&M code plus the additional procedure code, or are some of the procedure codes simply not recorded?

RESPONSE: No. A second record is not generated.

c. When did this method of recording mandatory E&M codes begin?

RESPONSE: It has always been DoD Policy to capture a mandatory E&M code in DoD Ambulatory data.

805. Regional health care trends may be affected by systematic population migration that would not be captured in the national health trend measurement, as described in the response to question #76.

a. Will the government consider including membership changes in the measurement of the national health care trend?

RESPONSE: No.

b. If not, will the government consider a bid price adjustment based on changes in membership?

RESPONSE: No.

806. Given that:

a. A significant number of current TRICARE eligibles are covered by other health insurance (OHI),
b. TRICARE benefits were significantly enriched over the last two years, while most commercial employers scaled back benefits and/or increased employee contribution requirements, and
c. The accuracy of information on other health insurance included in the government tapes is open to question (for instance, the OHI paid amounts often exceeds the OHI allowed amounts),

Will the government provide any supplemental information to help bidders understand cost increases driven by those eligibles that did not previously rely on the system, and program reliants that lapsed their other health insurance, choosing instead to rely completely on TRICARE?

RESPONSE: The data which has been provided includes all the available government information.

807. Reference H-1 b (2) (b&c) and H-3

a. If agreement cannot be reached on target costs for an option period in advance, will the 'estimated target cost' be used in the interim underwriting fee determination?

RESPONSE: Yes.

b. If the answer to question a) is 'yes', please explain why this approach would not understate the likely ultimate fee that will be earned (since trends are almost always positive) and thereby delay payment by upwards of one year.

RESPONSE: The fee that will ultimately be earned depends on the contractor's performance in meeting the estimated target cost. Even if "trends are almost always positive," contractor performance as well as any trends will determine the fee earned. The approach may either understate or overstate the fee that be ultimately earned.

808. The out-of-pocket (a.k.a. 'Cat Cap') limit for NADDs was reduced significantly at the start of Fiscal Year 2001. However, in many regions, this change was not actually implemented until much later. Can the government provide assurances that:

a. The retroactive effect of Cat Cap is fully and accurately included in the claims data provided, and

b. The allocation of costs by service category – particularly to pharmacy (which will be covered under a different contract) is accurate?

RESPONSE: As these are data fields completed by the contractors, no, the government cannot guarantee that the effect of the CAT CAP is fully and accurately specified in the data tapes. No, the government cannot guarantee that the allocation of costs by service category is correct, but the government has no reason to believe the distribution by service category is not correct.

809. Benefit payments for NADD Prime beneficiaries will be counted as a health care cost, while the related enrollment fee will be counted in administration. Given this, please explain how the government can fairly evaluate either administration or health care cost proposals without requiring disclosure of penetration assumptions.

RESPONSE: The Government will review the offeror's proposed target health care costs and evaluate all pricing factors considered by the offeror, including penetration. Offerors are required to provide justification for all assumptions made in developing proposed target health care costs. Conversely, the Government does not intend to evaluate administrative prices for reasonableness based on a review of individual elements of costs, and thus will not evaluate the effects of penetration, or any other specific pricing factors, an offeror assumes in developing its proposed prices.

810. Historically, the elapsed time between the effective date of a change order and final resolution ('definitization') often covers several years.

a. What reason is there to expect that this phenomenon will not occur under the new contract?

RESPONSE: We will not try to tell you what to expect, make commitments/predictions about the future, or to argue against your claim. We will however point out how this RFP is different from the prior generations of contracts, and point-out TMA's current practices. The RFP includes H-7, Integrated Process Teams, which was not in prior generations of contracts. To the maximum extent feasible, it is TMA's current practice to incorporate fully priced changes into the contracts by mutual agreement of the parties rather than issuing change orders. The practice in the past was to make all changes unilaterally as change orders. Also, the current staff levels are significantly higher than in the past and the pool (backlog) of undefinitized change order on current contracts is significantly lower than it was on prior generation of contracts when the current contracts were awarded.

b. If the phenomenon does occur, please clarify the extent to which national trends and 'final' underwriting fee calculations will be updated.

RESPONSE: The timing of definitization of change orders have no impact on the national trend. Definitization of a change order may result in a change in the target cost and target fee. If the target fee is changed as a result of a change order definitization by the parties after the underwriting fee is determined, the underwriting fee will be recalculated accordingly.

811. As pointed out in question #687, it is difficult to determine the government-required Prime Service Areas from the information provided on the data tapes. Although the inpatient MTFs and BRAC sites can be determined from the Catchment Area Directory (CAD) and the BRAC Pharmacy CAD files that were included as part of the data tapes, the government has not provided a definitive source to identify the outpatient MTF areas where Prime is required. As a follow-up to the posted response to question #68, would the government please provide a list of MTFs around which offerors are required to define the 40-mile Prime Service Area.

RESPONSE: We are unclear as to your first question on identifying the outpatient MTF areas. Prime is required in all MTF catchment areas (to include clinics) and BRAC sites. Please also refer to the response to Question 687. Also, to assist the offerors, we are posting documents (Power Point) that contains a map of all military MTFs, both inpatient/outpatient and outpatient (clinics) only.

812. When reviewing the TSC information provided as part of the data tapes, it appears that the data provided reflects the operation in the current MCS contracts - not necessarily where TSCs are required under this solicitation. Would the government please provide a list of MTFs where an on-site customer service presence is required?

RESPONSE: No. The requirement is that the contractor determine where to establish a customer service presence for all MHS eligible beneficiaries, including traveling beneficiaries, at each MTF, Prime service area, and BRAC site, either within the MTF, on the base, or if a BRAC site, at a location convenient to beneficiaries. This is determinable from the zip code files. Please also refer to the response to Question 687 and 811.

813. Throughout Section G, the RFP discusses how payments for claims costs will be made based on cleared TEDS. Since TEDS will be replacing the HCSR, can the government provide any statistics regarding whether or not there are any HCSR's under the current contracts that have never been accepted or approved? In other words, do all HCSR's that are submitted, eventually make it through the edit process?

RESPONSE: A comparison of HCSRs to TEDS is not valid. There have been many edit modifications and simplifications in TEDS. There may be a small number of HCSRs which are difficult to obtain a final resolution. These are normally worked continually by the contractors and the government until resolution.

814. If the answer to the above question is that there are some HCSR's that have never cleared, what are the reasons for the delay in clearing the edits? If the government is somehow at fault, how is the contractor to be reimbursed, and what is the mechanism for resolution?

RESPONSE: There are as many examples as there are edits, but one example in the delay in clearing an edit is when the Government and contractor disagree as to the application of the edit. All the edits are eventually cleared. There is no reimbursement issue because the contractor has already been paid for the health care, However, if the government is the problem these records are not counted against the performance standards.

815. For the subfactor 4 oral presentation, the RFP requires that the offeror present a "comprehensive description of and timeline for all start-up activities." Given the complexities involved in transitioning multiple regions under current MCS contracts to a single contract under this solicitation, transition in activities will include hundreds of major milestones involving thousands of high-level activities. Although this level of detail is included in written transition plans, it will require considerable time to present this same information in an oral presentation. Since the total oral presentation is only four hours in duration, and considering the fact that the relative weighting of subfactor 4 is less than subfactors 1, 2, and 3, we do not think the government intends for this level of detail to be presented in the oral presentation. Does the government expect the offeror to address the timeline and major activities for each major milestone as part of the oral presentation? If not, would the government please provide clarification on what should be included in the subfactor 4 presentation.

RESPONSE: Yes, we are clarifying the requirement in an upcoming amendment.

816. Your response to question 30 states that current network enrollees would not be forced to change their enrollments if the MTF had capacity at the start of the new contract. However, your response to Question 378 states that current network enrollees would require an exception from the MTF commander to remain enrolled with a civilian. Which is correct?

RESPONSE: Please refer to the revised response to Questions 30 and 378.

817. The August 2002 version of Chapter 6 of the TRICARE Ops Manual makes note of the enrollment year alignment to the fiscal year. How and when does the

Government envision this fiscal year alignment taking place for existing enrollees?

RESPONSE: The re-alignment of the existing enrollees takes place as the enrollees' enrollment anniversary occurs. For example, start of health care delivery is April 2004. A retiree's anniversary is Jun 1 2004, then the enrollment fees will be prorated to Oct 1, 2004 and the new enrollment anniversary date is Oct 1, 2004. Also refer to Change 2 to the TRICARE Operations Manual issued with a future amendment to the RFP.

818. Will the Contractor have access to CHCS for enrollment purposes?

RESPONSE: No. All enrollments with be through DOES to DEERS and DEERS will populate CHCS as needed.

819. Will a benefits review be required for specialty services provided by internal resource sharing specialists working in the MTF? If required, does the responsibility for the review reside with the Contractor or the MTF?

RESPONSE: We assume you asking about services proved by the internal resource sharing specialists working providing services the MTF, not those that have to refer care outside of the MTF to another specialist. Care rendered in the MTF by the resource sharing specialists in which MTF providers directly referred would not be reviewed by the contractor or the MTF. However, if care is referred from the civilian community to an MTF and it is assigned to a resource sharing provider, then a review required by RFP Section C-7.3.

820. Are annual enrollment related transactions numbers such as enrollments, disenrollments, PCM changes, etc., broken out by region available form the Government?

RESPONSE: A year's worth of monthly data by current regions on enrollments is being supplied on the web site. Data on monthly fluctuations is not available.

821 C-7.3.3 – "During the first full year of healthcare delivery, the contractor shall achieve the fiftieth (50th) percentile or above of all reporting plans on each measurement contained in the current National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS) for TRICARE Prime enrollees with network primary care managers. In all subsequent years, the contractor shall achieve their proposed percentile on each HEDIS measurement or above. If the requirement is not met, the contractor shall include with the annual report a detailed corrective action plan detailing the specific steps, and timelines for each step the contractor will take to meet the appropriate percentile of all reporting plans for the year being reported."

a. Regarding the achievement of the 50th percentile, please provide the reference that will be utilized to determine that percentile. For example, the 50th percentile for Beta Blockers, for Measurement Year 2000 (MY 2000), Reporting Year 2001 varies depending on the document referenced. For example:

   Quality Compass (QC) contains measurement results categorized by all States, Metro areas, census regions and HHS regions. For HHS Region 9, QC State: Band 3 (50th to 74th percentile) is from 93.53 - 94.89%.

In NCQA document "HEDIS Measures and HEDIS/CAHPS 2.0 Benchmarks and Thresholds for Accreditation 2002" there are separate 50th percentiles for each of the HHS regions ranging from 73 – 94%.

RESPONSE: An upcoming amendment will remove this requirement.

b. Within that reference please delineate which geographic categories should be utilized to compare each of the three TRICARE Regions?

RESPONSE: An upcoming amendment will remove this requirement.

c. Please indicate if the government intends to require the adult and child CAHPS surveys measures of the HEDIS measurement set.

RESPONSE: An upcoming amendment will remove this requirement.

d. This reference indicates that the first full year of healthcare delivery will be the first measurement year for HEDIS reporting and the answer to question #228 (…….the contractor submits its annual report to NCQA on meeting the HEDIS standards and after NCQA accepts it.) which would indicate that the HEDIS report is to be submitted to NCQA in accordance with other commercial health care plans which would require a full calendar year as the measurement year and HEDIS report submission to NCQA on June 15th of the following calendar year. Please clarify which measurement year is to be utilized and if the requirement is to submit the report to NCQA by June 15th of the following year. If not, please provide the specific timelines and process.

RESPONSE: An upcoming amendment will remove this requirement.

822. C-7.5 – "The contractor shall establish a system that ensures that care received outside the MTF and referred by the MTF for MTF enrollees is properly entered into the contractor's claims processing system to ensure the appropriate adjudication of claims for enrollee's care. The MTF will transmit referral information in a HIPAA compliant manner. The contractor, using its authority as a Peer Review Organization, shall apply its own utilization management practices to inpatient care received by MTF enrollees in a civilian setting that extends beyond the initial diagnosis related groups (DRG) for which the MTF authorization was issued."

a. Is it the governments intent that the contractor applies its own utilization management practices to ONLY inpatient care received by MTF enrollees in a civilian setting?

RESPONSE: It is the Government's intent that the contractor apply its own UM practices to only that inpatient care that exceeds the initial MTF authorization.

b. If yes, it is assumed that the expectation of the contractor is to not apply utilization management processes to outpatient civilian care referred by the MTF for MTF enrollees but only enter the referral into the contractor's claims processing system for appropriate adjudication of claims. Is this assumption correct? (It is understood that administrative coverage review for benefit determination will be performed on all referrals).

RESPONSE: Your assumption is correct. The Government has no requirement for the contractor to review the medical necessity and appropriateness determinations of the MTF Commander.

832A. C-7.7 requires that the contractor "shall operate a medical management program for all MHS eligible beneficiaries receiving care in the civilian sector". The second sentence of this requirement states that "The contractor's medical management program must fully support the services available within the MTF."

a. Please clarify the distinction made between managing care that beneficiaries receive in the civilian sector and supporting services available within the MTF. Is the Government requiring that the medical management program that is operated in the civilian sector will be the same program that the contractor will operate within the MTF? Or, is the contractor required to not perform medical management activities within the MTF, but support the services within the MTF by, for example, 1) channeling care into MTF available capacity and capability where they will be managed by MTF resources and 2) receive and facilitate care plans which move between direct care resources and purchased care resources?

RESPONSE: The contractor's medical management activities within the MTF are limited to those specified in Section C-7.7.1. The contractor is required to achieve the objectives of this contract through it contractor proposed activities. This includes optimizing the MTF as well as achieving beneficiary satisfaction and best value in health care services.

b. Which medical management program elements is the Government requiring the contractor to provide within the MTFs? Previous MSCS procurements have revealed variable tasks required by different MTF Commanders in medical program activities, reflecting different areas of management priorities and resource commitments by each MTF.

RESPONSE: Only those services required in Section C-7.7.1. will be allowed to occur within the MTF.

c. If the Government requires the contractor to implement any/all elements of its medical management program in all MTFs, would you please identify and clarify whether there are ongoing medical management programs which are in place by MTF, and whether the contractor would be expected to replace them, continue them or augment them?

RESPONSE: Please see our previous response.

823. Reference C-7.7.1.1 – "In cooperation with the MTF, the contractor shall coordinate the care and transfer of patients who require a transfer from one location to another. This function shall include coordination with the primary clinician at the losing and gaining sites, the patient's family, arranging medically appropriate patient transport, ensuring all necessary supplies are available during the transport and at the receiving location, arranging for and ensuring the presence of all necessary medical equipment during transport and at the receiving location, and identifying and ensuring the availability of necessary resources to accomplish the transfer. Transfers

may occur as a result of medical, social, or financial reasons and include moves of non-institutionalized and institutionalized patients."

a. The TOM definition of transfer claim is: "a claim received by a contractor which is for services received and billed from another contractor's jurisdiction". Does the Government have another reference that can be researched for "transfer of patient"?

RESPONSE: No.

b. Is this requirement about discharged planning and how the contractor may assist the MTF with patient transfers?

RESPONSE: No, this is a comprehensive program to assist those patients identified in Section C.7.7.1. when a transfer is required. Discharge planning is only a small piece of the requirement.**:**

824. C-7.9 - Your response to question #430 states, "It is the Government's requirement that all marketing and education materials, including newsletters and bulletins, to be furnished by the Marketing and Education contractor to the MCS contractor for distribution by the MCS contractor."

a. Who pays for mail and delivery costs to the MCS contractor, the beneficiary, the provider, and other interested parties?

RESPONSE: The Government will provide the materials to the contractor at Government expense. The MCSC will distribute the materials at MCSC expense.

b. If any of these costs are the responsibility of the MCS contractor, what data will you provide for cost estimating purposes?

RESPONSE: The RFP provides sufficient data to allow cost estimating.

825. C-7.21 - The government's response to question 104 was the requirement is for a single system that may be operated from multiple locations. Will the government permit foreign claims due to the variations in TRICARE Overseas Program (TOP) requirements to be processed on a separate claims processing system?

RESPONSE: Yes.

826. H-8.l. - We assume that the following conditions would be excluded from the universe of referrals considered under the standard: Beneficiary continuity of care, Traveling beneficiaries, Portability – beneficiary out of area. Is this understanding correct? Also, TRICARE Operations Manual 6010.51-M August 1, 2002 Chapter 1, Section 3, 1.2. Referrals states "96% of all referrals of beneficiaries residing in TRICARE Prime service areas (does not include TRICARE Prime Remote areas) shall be to the MTF or a civilian network provider. (This percentage includes services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual.)" The RFP Section H-8.l standard relating to this requirement makes no mention of the percentage including the services rendered in network institutions by hospital-based providers. Are the services of hospital-based providers rendered in network institutions to be included in the 96% for purposes of

assessing the performance guaranteed standard? If so, is it the government's intent that the contractor develop contracts with these providers?

RESPONSE: No, your understanding is not correct. The referrals in the situations mentioned should be to a network provider if an MTF in not available. Yes, the percentage does include hospital based clinicians. The requirement for an adequate network, as specified in Section C-7.1.9, includes hospital based providers.

827. Attachment L-1, page 3, second paragraph. "…..the contractor will receive telephone calls that are directly and automatically referred to the contractor by the Government's TRICARE Call Center." The response to question 500 states that, "the call will either be automated or a person to person call from the call center to the contractor."

a. What is the role of the people who answer the DoD's l-800-TRICARE number?

RESPONSE: The role of the DoD call center is to assist DoD, not the MCSC, in responding to questions and providing assistance when DoD does not have another mechanism.

b. Will the caller have the choice of selecting the DoD's IVR or being transferred to a live DoD person?

RESPONSE: While the DoD call center envisioned for implementation for the time period covered by the MCSC contracts has not been purchased, the idea is to not duplicate services being purchased from the MCSC or any other contractor.

c. What are the IVR options that the customer will hear when calling the l-800-TRICARE number?

RESPONSE: Please see our previous response.

d. What type of calls will be handled by the DoD call center?

RESPONSE: Please see our response to subpart "a" of this question.

e. What volume or percent of contract area calls will be completely handled at this number, so the contractor can staff appropriately?

RESPONSE: The contractor should anticipate answering all of these calls with the exception of those related to a call that could only be answered by another contractor. We do not have data to determine a percentage.

f. If a call is transferred to the contractor, will the contractor wrap-up the call with the customer?

RESPONSE: The MCSC will be responsible for wrapping up the call.

g. Will the government's beneficiary survey differentiate between which call center handled the call?

RESPONSE: A copy of the survey may be found at Section L, Attachment 3.

h. What indicator will be used in determining what contract area the call will be automatically transfer to?

RESPONSE: This is unknown at this time.

i. Should the contractor provide the government with the ability to transfer directly to a Customer Service Representative versus being routed to the contractor's switch, as indicated previously?

RESPONSE: The offeror may propose their best practices for fulfilling the requirement.

j. What will the 800 TRICARE personnel be trained on?

RESPONSE: This is yet to be determined.

k. Where will the 800 TRICARE number be published?

RESPONSE: Offerors may assume that the number will be widely published.

l. Is there a concern that the customer can be greeted inconsistently by the DOD and contractor during one call and can receive different IVR options, if IVR elected, at each call center?

RESPONSE: No, we believe proper management of both lines will eliminate this potential.

828. M-6.c, page 94 - The following question was asked to the Government with the Government's response following below.

> Question 52: "RFP Section M.6.c, page 94 states "Proposals will also be evaluated based on the offeror's approaches for achieving the 50th percentile of the NCQA's HEDIS measures based on all reporting plans for TRICARE Prime enrollees who are the fiscal responsibility of the offeror during the first two option periods of the contract will be evaluated." Will Military Treatment Facilities (MTF) be held to the same HEDIS requirements for their enrollees under this contract? If MTF are not held to this same standard, how will the government meet their goal of continuous health improvement of the TRICARE population? How will the government ensure a "fully integrated patient information system" based on information about the total TRICARE beneficiary population? Today, NCQA HEDIS standards for TRICARE do not exist. Please clarify what NCQA HEDIS standard will be followed - Commercial, Medicare, or Medicaid? (Received 16 August 2002)"

Response: The requirement for HEDIS will be removed in an upcoming amendment.

> The statement that "the internal operations of the MTFs are not the concern of this contract" clarifies many questions submitted to the Government that are unrelated to this HEDIS question but which have sought clarification on the relationship between the contractor and the MTF in several activities and to the scope of work that the Government expects of the contractor. Specific

examples, among many others, include C-7.7 which states that "the contractor's medical management program must fully support the services available within the MTF". C-7.7.1 states that "when care occurs within the MTF, the contractor is responsible for coordinating the care with the MTF staff as well as civilian providers."

a. Please confirm that the statement that "the internal operations of the MTFs are not the concern of this contract" clarifies that the contractor 's role is not to assist in the various medical management activities within the MTFs.

RESPONSE: This is not correct. Paragraphs C-7.7.1. and C-7.7.1.1., for instance, have specific requirements for Medical Management within the MTF. However, with the exceptions specifically listed in the RFP, the MCSC will not conduct medical management activities within the MTF.

b. Please also confirm that the contractor's role is to receive completed treatment plans for care rendered within MTFs and that once the treatment decisions have been made, the contractor is expected to receive, coordinate and facilitate those treatment plans from one MTF to another MTF or from MTF to purchased care provider.

RESPONSE: No, please refer to the specific requirements contained in C-7.7.1. and C-7.7.1.1. which require more than a passive response to MTF actions.

829. The August 2002 manuals still contain some references to Resource Support (TRICARE Reimbursement Manual, Introduction, page 2 and Chapter 4, Section 2, I.A and TRICARE Operations Manual, Chapter 4, Section 1, paragraph 9.1). We assume these references are in error and will be removed from the manuals. Is this a correct assumption?

RESPONSE: Yes.

830. TRICARE Operations Manual Chapter 15, Section 3, Paragraph 8.0. On page 5, it states the resource sharing report shall include "the number of outpatient visits and/or admissions "credited" to each agreement to meet the annual adjustment requirements". Since the bid price adjustment has been eliminated, what "annual adjustment requirement" remains for resource sharing?

RESPONSE: None. We will revise the manual.

831. TRICARE Operations Manual Chapter 16, Section 2, Paragraph 2.2. This sections states "The contractor shall submit the finalized plan to the Regional Director no later than 60 calendar days prior to the start of each new health care delivery option period". Given that transition will still be taking place for some of the current regions during the first part of Option Period I, will this due date be modified for the first Option Period? For instance, in the South could information on Regions 3/4 be submitted 60 days prior to August 1, 2004 (when the contractor is at-risk for health care costs) and in Region 6 be submitted 60 days prior to November 1, 2004 (when the contractor is at-risk for health care costs)?

RESPONSE: Yes.

832. TRICARE Operations Manual Chapter 16, Section 2, paragraph 8.0. This section references the TRICARE Policy Manual, Chapter 10. We assume this should be changed to Chapter 11, which deals with provider policy. Is this a correct assumption?

RESPONSE: You are correct. We will update the reference in a future amendment.

833. Under the current contracts, a standardized Financial Analysis Worksheet (FAW) must be completed for each resource sharing agreement entered into between the contractor and the MTF. A draft of the FAW is included in the TRICARE Operations Manual Chapter 16, Addendum C. The August 2002 Operations Manual has eliminated this document. Should we assume the FAW is no longer required?

RESPONSE: You are correct, a standardized form is not required; however, we expect the contractor to partner with the Regional Director to achieve the consistency necessary for both organizations to work effectively.

834. The definition for "Demand Management" was not included in the most recent version of the T-Nex Manuals. Please provide a current definition of "Demand Management."

RESPONSE: Demand management is a term of art that refers to any of a number of techniques designed to ensure that patients are treated at the appropriate time, in the appropriate setting, and by the appropriate clinician based on the patient's condition. Offerors are free to propose their demand management programs that will achieve the objectives and requirements of this contract.

835. TRICARE Operations Manual, Chapter 15, Section 3, paragraph 16 refers to a monthly report "Debt Collection Assistance Officer Program Report". It is our understanding that the DCAO is a government designated position in the Lead Agent or MTF responsible for providing assistance once an individual has been placed in collection status. It appears that the contractor is to provide the information for the report on the cases being worked by the government DCAO. Please clarify the contractors role in the creation of the report.

RESPONSE: The report is to be completed by the contractor on cases the contractor is working.

836. TRICARE Operations Manual, Chapter 13, Section 3, paragraph 4.1.1 through 4.1.5 (Reconsideration Reviewers) appears to conflict with the statement regarding reviewers for factual determinations found in TRICARE Operations Manual, Chapter 13, Section 5 [Appeal of Factual (Non-Medical Necessity)].

Assumption:

a. We assume, based on the guidelines found in Chapter 13, Section 5 which deal specifically with reconsiderations of factual denials, peer review is not always required for factual reconsiderations. In cases where no clinical issues are involved, the reconsideration determination can be made by an individual who has the background, training and authority to review complex benefit issues requiring a high degree of critical judgement as outlined in Chapter 13, Section 4.1.5. Please confirm assumption.

RESPONSE: We are in the process of revising Chapter 13, Section 3, paragraphs 4.1.1 through 4.1.5 to more clearly state peer review requirements. Your assumption is correct, that in cases where no clinical issues are involved, the reconsideration determination can be made by other than a peer.

b. Additionally, we assume that the requirements found in Chapter 13, Section 4.1.1 through 4.1.4 apply to medical necessity determinations which are less than fully favorable, or, in cases where the expertise of these individuals is warranted. In a situation where a medical necessity determination is fully favorable, we assume the determination can be made by a first level (RN or physician assistant) or second level (board certified physician) medical reviewer. Please confirm assumption.

RESPONSE: Your assumption is correct. The above-referenced revision will more clearly state when peer review is required.

837. In the TOM, Chapter 7, Section 4 , 1.0 there is a requirement for a CQMP Annual Plan and a format is included. No date of submission is mentioned. Please specify when the initial CQMP Annual Plan is due. Since it is an 'annual' plan, we expect the contractor is required to submit an updated plan each year. If so, please specify the due date for contractor's to submit an updated CQMP Annual Plan.

RESPONSE: The plan shall be submitted in accordance with the provisions of C-7.25 and F.5.(21) that states, "Initial submission within 30 calendar days of award; subsequent submissions due to updates or changes to the program are to be submitted within 10 calendar days of the update or changes."

838. Per the TOM, Chapter 7, Section 4, 2.0, the contractor is required to participate in monthly, or less frequently if directed by the Regional Director, 'region level' quality management committees. A reporting requirement specified in the TOM Chapter 15, Section 3, 10.0 requires the contractor to provide minutes of 'catchment area-specific' clinical quality assurance committee meetings on a quarterly basis. We believe the report requirement in Chapter 15 should refer to the minutes of the region level quality management committee, not catchment area specific clinical quality assurance committee meetings. Is this correct?

RESPONSE: Yes. A change to the TOM will be incorporated in an upcoming amendment.

839. We received a new package of data tapes earlier this week. Do these tapes totally replace the previous tapes - or do we add this data to the original data?

RESPONSE: The updated information you received on 26 August replaces the FY02 detail HCSRs received in the original data set. The detail HCSRs for care received in FY02 in the original data set reflected records accepted at TMA through May 02 while the updated set of FY02 records reflects care accepted through August 02. Bidders should use the detail HCSRs in the original data set for care received in FY01 since these records were not updated.

840. Reference your data provided in the file BRAC Pharm CAD 200207.txt and the Contract Region File: You show the following North Carolina Zip Codes associated

with Myrtle Beach BRAC (DMIS ID = 0102) in the South Region (Old Region 3). The Contract Region File shows that these Zip Codes are in Region 2.

28420, 28430, 28432, 28439, 28452, 28455, 28459, 28463, 28467, 28468, 28469, & 28470

Do you intend for these Zip Codes to be in the North Region or in the South Region? If you intend for them to be in the North Region, are they to be considered BRAC Zip Codes that define a required Prime Service Area in the North Region?

RESPONSE: These zip codes are in the Northern Region and do represent a Northern Region BRAC site requiring a Prime Service Area.

841. Reference your data provided in the file BRAC Pharm CAD 200207.txt: You show the following Zip Codes in the Wurtsmith BRAC (DMIS ID 0071):

48432, 48720, 48731, & 48755

These Zip Codes are on the south shore of Saginaw Bay. Other Zip Codes on the south shore (48445, 48445, and 48725) were excluded from the Wurtsmith catchment area because of the geographic barrier. Should these Zip Codes also be excluded from the Wurtsmith BRAC?

RESPONSE: No, these zip codes will remain in the Wurtsmith BRAC file.

842. Subsection C-7.1.16 states that the contractor shall ensure that network speciality providers provide clearly legible specialty care consultation or referral reports, operative reports and discharge summaries to the beneficiary's PCM within 10 working days of the encounter.

a) We assume that you are asking that consultation reports for an episode of care, not encounter reports, reach the PCM within 10 days. Is this correct?

RESPONSE: No, this is not correct. These reports are required to ensure that the PCM is cognizant of the treatment/recommendations of the specialist. Without this information, the PCM cannot appropriately treat the patient.

b) Are you referring to all operative procedures irregardless of where they occur, ie, physician office, ambulatory surgery center, outpatient hospital, and inpatient hospital?

RESPONSE: Yes.

c) Would both the provider and facility need to be network for this to apply?

RESPONSE: No, this is a clinical quality issue, not a network adequate issue.

d) Are operative reports from the date of the procedure or the date of discharge in the case of hospital admissions?

RESPONSE: Date of procedure.

e) Are you referring to the signed operative report that is part of the patient record? If yes, the hospital and JCAHO standard for having the signed operative report on the record in 30 days. Would you propose that TRICARE invoke a different standard? If yes, we believe that this may be an undo hardship on the providers and contractors.

RESPONSE: Yes, we're sure you'll agree that it is critical for post operative care that the PCM have a copy of the report.

f) Discharge summaries are not required to be signed and on the patient record for 30 days from date of discharge. Are you proposing that TRICARE have a different standard? If yes, would the discharge instructions be acceptable in lieu of the discharge summary?

RESPONSE: Yes, we are proposing a standard that directly affects patient care rather than one designed to ensure the completion of the patient's hospital record. Because this is a patient care issue, discharge instructions are inadequate to allow appropriate follow-up care by the PCM.

843. (841). Attachment J-4, paragraph 1.0 makes reference to the "MHS Information Assurance Policy Manual (Draft)of November 2001, as one of the manuals in which the Interim Approval To Operate (IATO) requirements are set forth. Please provide directions as to where the MHS Information Assurance Policy Manual (Draft)of November 2001 can be found on the TMA website, or advise how potential offerors can obtain a copy of this manual.

RESPONSE: The document, "MHS Information Assurance Policy/Guidance Manual" will be included in the TRICARE Systems Manual in a future change.

844. What standards, constraints, or regulations must the Government follow in negotiating the target cost for the next option period? This question relates to section H.1.b.(2)(b)

RESPONSE: There are no specific constraints that the Government will follow. The standards used to negotiate are found in the FAR. Any agreement must be fair and reasonable to both parties, contain only allowable and allocable health care costs, and be in compliance with the contract terms, FAR and DFARS.

845. Must the government agree to a target cost which it considers to be a best estimate cost? This question relates to section H.1.b.(2)(b)

RESPONSE: The Government will attempt to negotiate an agreement for target health care costs for a prospective option period that is mutually acceptable to both the contractor and the Government. This is clearly the preferred approach. However, as stated in H.1.b.(2)(b), if an agreement cannot be reached "by 30 days before the start of the next option period", the Government will exercise the next option period "using the prior option period's target cost". A target-setting formula will then be used to retroactively establish the final target cost at some future date.

846. Given the time constraints on reaching a settlement, what time constraints on placed on the government responding to proposals? This question relates to section H.1.b.(2)(b)

RESPONSE: Time constraints are included in H.1b.(2)(b). The Government intends to interact with the contractor in a coordinated effort to agree upon the target cost for each of the respective Option Periods II through V. This effort will take place as soon as practicable before the 11th month of a respective option period. The goal is a coordinated effort with the Government and the contractor working together in the development of a mutually acceptable target cost.

847. If the government is not satisfied with a proposal, will it make a counterproposal? This question relates to section H.1.b.(2)(b)

RESPONSE: The Government will not make a "counterproposal" in the formal sense that the question implies. The negotiation of the target costs on this contract will involve discussions of the contractor's cost-estimating methodology as well as consideration of recommendations the Government might bring to the process.

848. In Chapter 9 of the TPM, there is a conflict concerning the authorized benefit period for a specific Program for Persons with Disabilities (PFPWD) service or item. Section 2.1, paragraph I.A., states that the PFPWD benefit authorization period is defined as beginning on the date of issuance and continuing for not more than six (6) months. Section 3.1, paragraph I.C., states that the authorization for a particular PFPWD service or item shall not exceed twelve (12) consecutive months beginning on the date the authorization is issued. Please clarify whether the PFPWD authorized benefit period is to be for six (6) months or twelve (12) months.

RESPONSE: We will be updating the Policy Manual in an upcoming amendment to reflect the 12-month authorization period.

849. Regarding HEDIS, unique characteristics of the MHS (patient possession of MTF medical records, highly mobile population, mixed delivery system of direct and indirect care, and incomplete administrative data including claims) will prevent contractors from following NCQA technical specifications in data collection. If contractors devise modifications in the technical specifications, then the data cannot be submitted to NCQA using HEDIS submission tools. Variations in data collection methodologies will affect the ability to compare results for the MHS population to commercial health plans. Similar issues resulted in different versions of HEDIS to serve Medicaid and Medicare populations. Would the government meet with potential contractors and NCQA to develop a TRICARE version of HEDIS technical specifications and data submission standards?

RESPONSE: The HEDIS requirements will be eliminated in an upcoming amendment.

850. The TRICARE Operations Manual, Chapter 6, Section 1, 3.1.1 requires the contractor to perform MTF PCM by name re-assignment in DOES within three calendar days of the effective date of the PCM's reassignment. The TRICARE System's Manual, Chapter 3, Section 1.5, 1.2.7.2. indicates the PCM Panel Reassignment Application is used to batch move a civilian PCM's enrollees. We have the following questions regarding this application.

a) Can the PCM Panel Reassignment Application also be used to move beneficiaries assigned to direct care (MTF) PCMs?

RESPONSE: No. The Civilian PCM Panel Reassignment Application and the web application used for Direct Care PCM Panel Reassignments are separate applications. The Civilian PCM Panel Reassignment Application may not be used to perform Direct Care PCM Panel Reassignments. Please refer to the TRICARE Systems Manual, Chapter 3, Section 1.5, Subsection 1.2.5.2. for a description of how batch moves for Direct Care PCMs may be accomplished.

b) If so, does the application function the same as described for civilian PCM moves?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 3, Section 1.5, Subsection 1.2.5.2., for a description of how batch moves for Direct Care PCMs may be accomplished. Direct Care PCM Panel Reassignments are to be performed in accordance with criteria established by the MTF. Civilian PCM Panel Reassignments are performed based on the MCSC need to move an entire civilian network PCM's panel to another civilian network PCM.

c) If the PCM panel Reassignment Application cannot be used for the reassignment of direct care PCM, will DMDC accept and load a contractor's file containing batch MTF PCM reassignments?

RESPONSE: No. Direct Care PCM Panel Reassignments are performed through a web view of the CHCS batch PCM change process.

d) Will the contractor be notified of the reassignment needs at least three calendar days prior to the effective date of reassignment of the direct care PCM?

RESPONSE: The contractor will be notified of Direct Care PCM Panel Reassignments in accordance with timelines contained in the Memoranda of Understanding (MOU) the contractor establishes with the MTF commanders. Since the contractor is required to perform the reassignment moves within three calendar days of the effective date of the PCM's reassignment, the contractor should ensure that the MOUs stipulate when the contractor will be notified by the MTF of the need for the reassignment and whether the moves must be performed within three days prior to or after the effective date of the PCM's reassignment.

851. Replicate of question 848. Revised 25 September, 2002.

852. Replicate of question 849. Revised 25 September, 2002.

853. Replicate of question 850. Revised 25 September, 2002.

854. Will there be Contracting Officer's Representatives (COR) or Contracting Officer's Technical Representatives (COTR) at each military treatment facility (MTF)as there are under the current MCSCs? If yes, will there also be alternate CORs or COTRs at each MTF?

RESPONSE: It is the Government's intent to have a COR at each MTF. Depending on the size of the MTF, there may or may not be an alternate COR.

855. Is there a detailed agenda available for the T-NEX Information Technology Conference scheduled for 10/2/02?

RESPONSE: The agenda is as follows:

TRICARE T-NEX INFORMATION TECHNOLOGY (IT)

CONFERENCE
AGENDA

Doubletree Hotel, Denver Southeast
13696 E. Iliff Place
Aurora, CO 80014

WEDNESDAY, OCTOBER 2, 2002

12:30 PM	**Administrative Remarks** Introductions Overview of Pre-Proposal Conference	**John Meeker**
12:40 PM	**Welcome**	**Jim Reardon**
12:50 PM	**DEERS**	**Janine Groth**
2:50 PM	***BREAK***	
3:00 PM	**TRICARE On-Line**	**CAPT Brian Kelly**
4:00 PM	**CHCS**	**Lt Col Bart Harmon**
5:00 PM	***BREAK***	
5:10 PM	**Duplicate Claims**	**Pete Koste**
5:40 PM	**DITSCAP**	**Dorothy Williams**
6:00 PM	***ADJOURN***	

856. Will the T-NEX Information Technology Conference scheduled for 10/2/02 discuss the applications (DEERS, CHCS) themselves (what they do, how they are used), or will the specifications for the technical linkages to these systems be reviewed? or both?

RESPONSE: The T-Nex Information Technology Conference will discuss the applications. The conference will not address the technical specifications.

We received a new package of data tapes on September 17, 2002.

a. Do these tapes totally replace the previous tapes - or do we add this data to the original data?

RESPONSE: The updated information you received on 26 August replaces the FY02 detail HCSRs received in the original data set. The detail HCSRs for care received in FY02 in the original data set reflected records accepted at TMA through May 02 while the updated set of FY02 records reflects care accepted through August 02. Bidders should use the detail HCSRs in the original data set for care received in FY01 since these records were not updated. The remainder of the data package is not affected.

857. The TRICARE Operations Manual dated August 26, 2002, Chapter 6, Section 1, 11.3, TRICARE Eligibility Changes: the last sentence states, "The contractor shall record reimbursements of fees in DEERS." The Systems Manual does not appear to address the recording of reimbursements in DEERS. How will this be accomplished? Also, will the contractor only be required to record reimbursements of fee as a result of beneficiary death, or in all other instances?

RESPONSE: Fee reimbursements will be posted to DEERS through negative adjustments. All instances of fee reimbursements shall be posted to DEERS including those associated with the death of one or more family members, and those associated with TRICARE enrollees who have been recalled to active duty, (see TRICARE Operations Manual, Chapter 6, Section 1, Subsection 11.0).

858. The data package included zip codes where there is entitlement to the TRICARE pharmacy benefit. Why?

RESPONSE: We assume you are referring to the BRAC zip codes; Prime is required in all BRAC areas.

859. The data package included CHAMPVA eligibles by zip code. Why?

RESPONSE: We thought it would be helpful to offerors to know where CHAMPVA beneficiaries were located in preparing their network plans for implementing RFP Sections C-7.1.6. and C-7.1.6.1, and their customer service plans for implementing Sections C-7.1.13 and C-7.16.

860. We would to confirm whether the following types of costs should be included in Target Health Care Cost (i.e., risk is borne by the contractor), or if these costs are the government's liability. Please also indicate how such care is reflected in the historical claim data provided (e.g., excluded, in direct care encounter data, or in purchased care data).

a. ADs that are referred to network providers.

RESPONSE: These costs are excluded from the target health care costs. Care is included in the purchased care data.

b. ADD/NADDs enrolled with an MTF PCM, but referred to network providers.

RESPONSE: These costs are included in the target health care costs. Care is included in the purchased care data.

c. ADD/NADDs enrolled with a network PCM, but referred to the MTF.

RESPONSE: The costs of civilian care are included in the target health care costs. There are no MTF costs to include in the target. Care is included in the direct care data.

d. Non-enrolled MHS beneficiaries receiving care at the MTF.

RESPONSE: There are no MTF costs to include in the target. Care is included in the direct care data.

e. Resource sharing encounters within the MTF.

RESPONSE: The cost of resource sharing health care is included. The cost of the encounter administrative costs are excluded. Resource sharing is an underwritten cost, but in estimating the OP 1 target health care cost, offerors are not to assume any resource sharing per the instructions in Section L. Fee for service resource sharing costs are included in the historical purchased care data, but the Government does not believe all salaried resource sharing costs are included in the historical purchased care data. Resource sharing workload is included, although not separately identifiable, in the historical direct care data.

f. If an MHS beneficiary receives care in a different region or OCONUS. Does it matter if they are enrolled with an MTF PCM, a network PCM or non-enrolled?

RESPONSE: For the purposes of determining the target cost, it does not matter. Civilian care is included in the purchased care data. MTF care is included in direct care data.

g. All services to TFL beneficiaries are excluded from this contract, whether the cost is for Medicare-covered benefits or benefits above Medicare coverage.

RESPONSE: You are correct. Care has been excluded from the purchased care data.

h. After excluding the AD claims, is all data on the HCSRs provided the sum total of what the contractor is at risk for?

RESPONSE: The risk arrangements reflected by the current HCSRs are very different from those included in this contract. As such, offeror's must project their risk based on the appropriate application of the data – not the risk arrangement. The criteria for what purchased care is subject to underwriting in this procurement is presented in Section H.1.a(1). Offerors should consult this paragraph in determining what historical HCSR data provided fall under these criteria.

i. Confirm that costs are not underwritten for TRICARE Plus and USFHP members.

RESPONSE: TRICARE Plus costs that are covered by this contract for beneficiaries not eligible for Medicare and who receive care outside of the direct care system are included. USFHP members are excluded from coverage and benefits under the MCSC contract. TRICARE Plus care is included in the purchased care and direct care data but not specifically identified.

861. Section H-1.b. (5) of the RFP states that Actual Costs include some non-TED benefits. We assume such costs are not in the historical claim data provided. How do we account for such costs in the Target Health Care Cost?

RESPONSE: The only underwritten costs that potentially would not be reported on TEDs would be resource sharing costs. Section L provides instructions on treatment of resource sharing for purposes of estimating the OP 1 target health care cost.

862. Can you provide information on the number of ADDs in Prime Remote areas that have elected the new Prime enrollment option, or at least the number that are eligible to do so? On what date did the interim "waived charges" benefit begin?

RESPONSE: Enrollment for the TRICARE Prime Remote for Active Duty Family Members (TPRADFM) Program started on Aug 12, 2002. During the first six weeks of the enrollment opportunity period 22,309 active duty family members out of approximately 120,000 potential families have enrolled. The interim "waiver of charges" benefits began on August 1, 2001 for care dates of service from October 30, 2000 through August 31, 2002. It ended upon the implementation of TPRADFM on September 1, 2002.

863. Please confirm that TRICARE Plus claims are to be excluded from the Target Health Care Cost? Have these claims been excluded from both the purchased care and direct care data provided?

RESPONSE: TRICARE Plus claims for beneficiaries covered under this contract are not excluded. TRICARE Plus care is included in the purchased care and direct care data but not specifically identified.

864. The RFP outlines a methodology for assigning responsibility for newborn claims (Section H-10). How does this differ from the methodology in place during the experience period for which claim data is provided?

RESPONSE: Regarding historical claims data for newborns during the first 120 days of life, PCM coding prior to formal enrollment varied contract by contract. However, offerors are reminded that PCM assignment is not a criteria for determining whether or not underwriting applies under this procurement. Thus, the RFP methodology for assigning newborn claims in the absence of formal enrollment and PCM assignment does not affect underwriting status. Rather, this methodology shall be used to determine where the contractor will invoice for these costs (e.g., a particular MTF, or TMA-Aurora).

865. Are BRAC areas designated as Catchment areas in the claim data provided? And do they have a Catchment DMIS ID assigned?

RESPONSE: No to both questions.

866. Are cancer clinical trial costs included in the claim data provided?

RESPONSE: No, this care is not reported on a HCSR but is reported to Resource Management via paper vouchers.

867. The summary claim data for purchased care includes a designation by category of care. The definitions do not indicate where surgical and diagnostic testing CPT codes are assigned. Are these included with Office Visits (even though this is defined as just the evaluation and management CPT codes)?

RESPONSE: That is incorrect. he historical Data package for purchased care contains a "Category of Care Definitions" section which defines the category for each procedure code. For example, there are specific codes listed that are assigned to the surgical professional component in the summary data. The surgical and diagnostic care would not be included with office visits.

868. The total "Government Cost" on the summary HCSR files does not match the "Amount Paid by Government Contractor" on the detail file for fiscal year 2001. (The detail total was determined by summing all header files with a "end date" of September 30, 2001 or earlier.) Please explain why not.

RESPONSE: HSCR data is summarized into the summary files based on the end dates of care for the individual HCSRs. The data element called "Fiscal Year End date of Care" in the detail record is the best data element to use for summarizing care received in FY01. Any differences between the detail and the summary file government cost should be extremely minor. Please be aware that there are many records in the HCSR detail with no government cost that are not used in the summary files.

869. Section G-3.a.(m) states that one of the payments by TMA Aurora is for "non-underwritten benefits". What are these? Also, this section indicates that some of these are "supported by a TEDs submission". Do the historical data tapes provided include such costs? If so, how can they be identified and excluded from the target health care cost?

RESPONSE *Revised 24 December 2002*

RESPONSE: Non-underwritten benefits are certain programs that are not in the Target Health Care Cost for various reasons. Some are not for individual beneficiaries, such as Capital Equipment and Direct Medical Education (CAP/DME) payments. This is paid to hospitals based on percentage of bedspace so they are not done through TEDS or HCSRs. Most of the other programs that are non-underwritten will be on TEDS and are currently on HCSRs. Examples of these include Supplemental Health Care (SHCP), and Foreign claims. One that will change on the new contracts is the Expanded Cancer Demonstration which is currently done manually and is not on HCSRs but will be on TEDS. Section H-1 of the proposal lists the non- underwritten programs.

Retail and mail order pharmacy services are excluded from the purchased care data. Active Duty/Supplemental and TPR for service members are included in the purchased care data. All CHCBP and Foreign/OCONUS care is included in the South Region. Cancer/Clinical Trials care is excluded from the purchased care data.

870. Section G-3.b.(1). Explain what is meant by "revised financing-MTF Prime enrollees and also AD supplemental care." The second sentence states that the payments are for civilian claims provided to MTF enrollees (AD, ADD, NADD). Aren't the ADD and NADD portion underwritten costs and would be paid by TMA, not the MTFs?

RESPONSE: Revised Financing refers to the arrangement where the contractor bills and is reimbursed by the MTF for care provided in the civilian sector for MTF Prime CHAMPUS enrolled beneficiaries. AD Supplemental Care refers to AD network care for MTF enrolled and will be paid by the MTF, for non enrolled AD the payments will

be made by TMA Aurora as defined in the RFP. MTF Prime enrolled ADD, and NADD network care is underwritten, their bills will be paid by the MTF as defined in the RFP.

871. The RFP mentions in a couple of places that enrollment fees should be excluded from target and actual health care costs. Is any special adjustment necessary to delete such costs from the historical data tapes provided?

RESPONSE: No.

872. The direct care data includes a maximum of four CPT codes per encounter. Are additional services reported and, if so, how?

RESPONSE: Please refer to the answer to Question 804.

873. Please explain what is meant by "transitional direct care" (one of the Medical Privilege Codes in the eligibility summary files).

RESPONSE: The TAMP benefit for Direct Care is similar to the TAMP benefit in the purchased care. This is a temporary medical benefit extended to active duty leaving military service under certain conditions. See the Policy Manual, Chapter 10, Section 5.1.

874. C-7.28 requires the contractor locate a "…senior executive with the authority to obligate the contractor's resources within the scope of this contract within a fifteen-minute drive of the TRICARE Regional Administrative Contracting Officer's (ACO) office."

a. Why? Please provide examples of situations in which the Government feels it is a requirement that the contractor's senior executive must be located within a fifteen-minute drive of the ACO's office and why telephone, fax or video teleconference technologies would not satisfactorily serve the government's need to communicate with the senior executive.

RESPONSE: The Government's experience has demonstrated that having a senior contractor representative immediately available significantly adds to the partnering relationship and the ability of both the Government and the contractor to collaborate.

b. Since there appears to be some urgency in the requirement to have a senior executive within a fifteen-minute drive of the ACO's office, does this mean the government expects the contractor's senior executive to always remain within a fifteen-minute drive of the ACO's office? If so, during what hours of the day and days of the week? How much advance notification will the senior executive receive from the government to attend a meeting in the ACO's office? Who will be authorized on the government's behalf to request the senior executive's presence in the ACO's office?

RESPONSE: The intent is to have the senior executive within a 15 minute drive time during normal business hours. The Government will not specify a level of day-to-day operational management but offerors should be aware that at times planned and formally scheduled meetings are just not possible during an immediate need situation. Who will request the senior executive will be determined by the ACO but common sense would indicate that if the Regional Director, the Deputy or the ACO requests that the contractor's executive attend a meeting that would be sufficient.

875. Repeated post of question 848. Revised 23 October 2002.

876. Repeated post of question 849. Revised 23 October 2002.

877. Repeated post of question 850. Revised 23 October 2002

Question 878 refers to L.12.c as amended in Amendment 0002

878. As amended in Amendment 0002, Subsection L.12.c permits a company to be awarded a contract as a prime contractor in one TRICARE Region and team with a potential prime contractor as a subcontractor in one or both of the other contracts awarded under the solicitation. Therefore, if one offeror is awarded a prime contract in Region X, and a second offeror is awarded a prime contract in Region Y and undertakes full responsibility to the Government for all aspects of performing the prime contract in Region Y, the Region Y prime contractor can award a subcontract to the Region X prime contractor and can align performance incentives by establishing a target cost and fee curve in that subcontract so that the subcontractor undertakes responsibility to the prime contractor for a reasonable portion of the financial risk borne by the prime contractor under Subsection H-1 in Region Y. Is this correct?

Response: *Revised 24 October, 2002*
RESPONSE: Yes, a prime contractor on one contract may be a subcontractor under any of the other contracts. The RFP does not specifically restrict performance, financial risk, or underwriting arrangements between a prime contractor and it's subcontractors. However, the Contracting Officer will award a contract to a prospective contractor only if the Contracting Officer makes an affirmative determination of responsibility in accordance with FAR Subpart 9.1. Once awarded, the Government will only have privity of contract with the prime contractor and will hold the prime accountable. See #924 for additional discussion.

879. Which payor companies(prospective offerors) in the southeast (regions 3 & 4) have received rfps for contract consideration in supporting managed care services? Is this list available via website?

RESPONSE: The solicitation mailing list is available on the TRICARE web site for this solicitation.

880. Will parties other than the Managed Care Support contractor have the opportunity to perform Resource Sharing?

RESPONSE: Current resource sharing activities are not a part of this contract. New resource sharing initiatives is an integral component of this RFP. As such, the Government will contract with a single source to provide all services. However, the "prime" contractor may elect to subcontract any of a number of services, including resource sharing to other parties.

881. Will offerors' proposed arrangement for Resource Sharing be evaluated, and, if so, how?

RESPONSE: The Government will evaluate proposals in accordance with Sections M-6 and M-8 of the RFP.

882. Will there be an opportunity for site visits at the MTFs?

RESPONSE: Yes, a site visit was held at Ft. Carson, CO and Peterson AFB, CO on Friday, October 4, 2002. A third site visit was conducted at the Naval Medical Center Portsmouth, VA on Tuesday, October 8. Please see the solicitation web site for additional details.

883. Will you please provide a list of the pre-proposal conference attendees?

RESPONSE: The list is available on the solicitation web site.

884. During the Pre-Proposal Conference (See Transcript Pages 66-67) Captain Tinling states that the Government will share with the MTFs its portion of the difference between target healthcare cost and actual healthcare cost.

> a) Is it correct that the Government will indeed directly share savings with the MTFs?

RESPONSE: The Government's internal distribution of any potential savings as a result of resource sharing are outside the scope of the RFP.

> b) Does the MTF share in all savings even if they were not involved in generating the savings?

RESPONSE: Please see our previous response.

> c) Will the Government provide a detailed description of how risk sharing will work? Specifically, will the Government provide more information on incentives for MTFs to provide care to TRICARE eligibles other than Prime members enrolled with MTF PCMs?

RESPONSE: We believe the RFP is clear and that any speculation on the future distribution of internal Government funds is inappropriate in relation to this RFP.

885. Question #633 and the govt response would seem to empower subsequent MCS contractors to deny Prime enrollment to beneficiaries not residing in Prime Required areas. Is it the intent of the govt for the contractor to be able to execute such an exclusion? If so, is there statutory support for this?

RESPONSE: No, that is not the intent. While the MCS contractors are not specifically required to offer enrollments to beneficiaries not residing in Prime areas, the TRICARE Regulation, 32 CFR 199.17 Section C. states "Where the TRICARE Program is implemented, all CHAMPUS eligible beneficiaries are eligible to enroll." Therefore, at the beneficiary's option, the contractor must honor a non-Prime area resident's request to enroll but the beneficiary must waive the access standards (TOM, Chapter 5, Section 1, Paragraph 1.0).

886. Reference C-7.21.17 & 18: Will contractors still be able to make administrative "inducement payments" to providers for joining the network? If so, must such payments be reported to the government? We assume such payments are NOT reportable as health care costs.

RESPONSE: Yes, the contractor may make "inducement payments" to ensure network adequacy. The payments must come from contractor funds, not be related to specific procedure-by-procedure reimbursement amounts, and are not reported on TEDS or any other Government report.

887. Question 887 was merged into question 888. October 3, 2002

888. Question 89 pertains to the case management CLIN. The Government has responded that "offerors may not input any unit price and amount other than the Government provided estimate for the case management/disease management CLINS." The Government refer the offerors to the FAR for guidelines on cost reimbursable contracts. FAR16.301-1 states "Cost-reimbursement types of contracts provide for payment allowed incurred costs, to the extent prescribed in the contract. These contracts establish an estimate of total cost for the purpose of obligating funds and establishing a ceiling that the contractor may not exceed (except at its own risk) without the approval of the contracting officer." Per the FAR, the contractor is at its own risk for anything above the government funded ceiling. At the Government proposed dollar levels existing case management services in at least one Region would be severely degradated. This is especially true in that the Contractor would need to follow its existing cost accounting practices and apply indirect costs to the direct labor. The contractor is also being asked to bid a health care price in which the contractor is having to make assumptions on case management services to build up and trend health care costs. The contractors are also being tasked with providing the highest beneficiary satisfaction possible and to provide continuous and seamless services.

RESPONSE: Amendment 0004 removed case management from the case management/disease management CLIN. This will allow offeror's to include case management costs in the per member per month rate. The Government has also increased the estimate on the disease management CLIN.

If during contract performance, it is evident that the actual costs of this program will exceed the Government estimate or will exceed the percentage set forth in FAR 52.232-20, Limitation of Cost, (incorporated into the contract at Section I.65) the contractor shall notify the Contracting Officer. The Contracting Officer may increase the cost estimate and funding. The contractor is not obligated to incur costs over the original estimate until additional funding is obligated. Should the contractor exceed the estimated cost without additional funding, the Government is not obligated to reimburse the contractor. If during contract performance, the contractor believes that services expected to exceed the estimated cost are necessary or beneficial to the Government, the contractor should justify the services and costs and seek approval from the Regional Administrative Contracting Officer in accordance with Section C. The Contracting Officer may approve services with higher estimated costs when only when funds are available and the services otherwise meet Government objectives. Offers should be prepared, however, with proposed services within the Government estimate, and should not anticipate an increase in the Government estimates set forth in Section B.

889. The Question 86 Government response states that the contractor is not prohibited from invoicing amounts above the maximum Government amount as it is cost reimbursable. We, however, believe that the FAR is clear as this will be at the contractor's risk and the funding will be at the sole discretion of the Government. We also believe the Contracting Officer cannot make obligations over what is

contractually agreed to and what is funded. Thus, as far as building health care and administrative costs, what assumptions should the contractor make as far as guaranteed funding?

RESPONSE: See response to 888 above.

890. L.12.f.(2).(a) refers. Question #414 asked if TMA will allow references signed within 60 days of the intial submission date and TMA responded that "this is a reasonable request and acceptable." Is it TMA's intention to incorporate this response in a future Amendment to the solicitation, or is TMA's response to the question considered sufficient?

RESPONSE: It is the Government's intent to amend the solicitation in a future amendment.

891. The Government's response to Question #585 states, in part, "MTF Optimization is defined in the TRICARE Operations Manual, Appendix A as 'Military Treatment Facility (MTF) Optimization: Filling every appointment and bed available within the MTF with the appropriate patient based on the capacity and capabilities of the MTF and the MTF's readiness/training requirements, as defined by the MTF Commander.' This is very different from and must not be confused with MHS Optimization which is a management philosophy employed by military medical leadership to manage the health of our beneficiaries while achieving our mission. The contractor role is a small piece of MHS Optimization limited to providing an adequate pool of patients to MTF Commanders. Achieving this impacts many contractor operations including, but not limited to, enrollment in both TRICARE Prime and TRICARE Plus, beneficiary education, provider education, medical management, and networks that support but do not detract from the MTF." Section L.13.3(1): "Subfactor 1- Support the MHS in the optimization of the delivery of health care services in the direct care system..." seems to focus on MTF Optimization as defined above. Section M.6.a., titles Subfactor 1 as "MHS Optimization" and could lead an offeror to focus on MHS Optimization. Will the Government evaluate Subfactor 1 from the perspective of MTF Optimization or MHS Optimization?

RESPONSE: It will be from the perspective of MTF Optimization; please refer to RFP Amendment 0003.

892. The response to question 794 states "…Then offerors must propose standards where the Government has a requirement but has not mandated a minimum standard…."

a. Please provide offeror's a listing of those requirements that the government was referencing in this response, or,

b. Please confirm that offeror's should interpret this response to mean they must include every contract requirement from the RFP, Operations Manual, Policy Manual, Reimbursement Manual, Systems Manual and CFR 199 as proposed standards, or,

c. Please provider offeror's a listing of those requirements the offeror can choose to submit a performance standard for.

RESPONSE: Offerors must review Section C, the standards listed in the TRICARE Operations Manual, Chapter 1, and its own procedures and methodology they will be offering to the Government to determine what standards they are to propose.

893. To ensure clear understanding of the government's submission requirements and enable the government to equitably evaluate proposals, please describe the precise format that the government expects for the performance standard submission. In addition, please answer the following specific questions regarding performance standards.

RESPONSE: There is no expressed format. Offerors may use a table form, Excel worksheet or other method that will be clear to the Government as to what is being proposed. These proposed standards will be incorporated into the contract document.

a. Does the government want a listing of all those requirements being proposed as performance standards? Should this listing be in a simple table with Column 1 listing the government requirement and Column 2 listing the offeror's proposed standard?

RESPONSE: See the answer to Question 892. Again, there is no format but a simple listing would meet the requirement.

b. Does the government want offeror's to describe, in a narrative, how the offeror will perform the necessary tasks, for each proposed performance standard, that will ensure the performance standard is met?

RESPONSE: A description of how the offeror will meet the proposed performance standards is to be covered in the oral presentation.

c. Does the government want offeror's to describe how they will measure each and every requirement included as a performance standard?

RESPONSE: A description of how the offeror will measure each standard is to be covered in the oral presentation.

d. Does the government expect offeror's to describe the organizational structure and lines of authority for each performance standard it is proposing?

RESPONSE: At the discretion of each offeror, that may be covered in the oral presentations.

e. Will an offeror that provides more detailed information on their performance standards be evaluated more favorably than an offeror simply listing the government requirements and their associated performance standard? If so, what are the specific components of a detailed answer the government wishes to see? (i.e., performance standard, organizational structure, narrative description of how the task will be accomplished,

relation to other areas of the business, interface points with the government and other contractors, etc.)

RESPONSE: Section L-14f.(1)(a) requires a written submission of the offeror's proposed standards. All other detail will be covered in the oral presentation as supported by the oral presentation slides. Content of the oral presentation will not be directed by the Government and discussion of what will be evaluated more favorably will not be addressed in this forum.

894. Will an offeror who is proposing a greater number of contract requirements to be measured as performance standards be evaluated more favorably than an offeror proposing a fewer number?

RESPONSE *REVISED 30 December 2002*

RESPONSE: Please see the response to Question 793 and 794; plus Section M.3 of the solicitation.

895. Given your response to Question 659, would the government allow an offeror to use a single medical management module/system integrated with two (2) claim adjudication and payment systems (each claim system would use the same medical management edits/audits), if the Prime contractor accepted responsibility for verifying and auditing the output for consistency? Time is of the essence so a quick response would be greatly appreciated.

RESPONSE: No. We must reiterate our position as stated in Questions 102, 192, and 659, and in the RFP Section C-7.21 that the contractor shall establish an automated information system (not multiple systems) and that the claims processing system shall be a single, HIPAA compliant system. Also, the Government, as indicated by Objective 5, desires to access only one data base to obtain all necessary information to conduct the TRICARE Program.

a) Supplemental Question: Will the government permit an offeror to contract with two claims processing subcontractors in either the West or South regions (where two different claims processing companies perform these responsibilities today)?

RESPONSE: Yes. Prime contractors may have as many subcontractors as they deem necessary to perform using a single claims processing system and other claims processing functions. As indicated by the answers to Questions 102 and 192, the single system may be operated from multiple locations to include multiple data entry sites.

896. We need clarification of what is counted as referrals as covered in the following references:

1) RFP Section C-7.3.2 states: "Ninety-six percent of referrals of MHS beneficiaries, residing in TRICARE Prime service areas who seek care through the contractor, shall be referred to the MTF or a civilian network provider. This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual. The contractor shall achieve improved performance levels related to this requirement in each contract period. The Administrative Contracting

Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception."

2) RFP Section H-8.l states: "Contractor Network Adequacy Standard: Not less than 96 percent of contractor referrals within a Prime service area shall be to a MTF or network provider with an appointment available within the access standards. …For purposes of this provision, a referral is the offer of an appropriate appointment within the access standards …"

3) TOM Appendix A; "**REFERRAL:** The process of the contractor directing an MHS beneficiary to a network or non-network provider."

a) In Section C-7.3.2 it appears that ' referrals' include referrals for beneficiaries residing in Prime Service Areas regardless of the location of the referred-to provider, while in Section H-8.1, it appears that 'referrals' include referrals to providers in a Prime Service Areas regardless of where the beneficiary resides. Is this correct?

Response: No, both references apply to referrals of beneficiaries residing within the prime service area. We will clairfy the Section H reference in an upcoming amendment.

b) In Section C-7.3.2 you include the services of hospital-based providers even though no formal referral is made to these individuals. It appears that you intend that each service rendered by a hospital-based provider be considered a referral; however, this is inconsistent with the definition of a referral as "The process of the contractor directing an MHS beneficiary to a … provider." Generally one would consider the process of directing a beneficiary to a source of care as one referral regardless of the number of services rendered during the resulting episode of care. Will the government please clarify what should be counted as a referral when responding the to requirement in Section C-7.3.2?

Response: Beneficiaries are actually referred to obtain a service. The contractor is required to develop networks of providers who render all services authorized for reimbursement through TRICARE. As such, when the contractor refers a beneficiary for a service all components of that services are to be rendered by network providers. For example, if you refer a beneficiary for surgery, care will be rendered by the hospital, surgeon, assistance surgeon, anesthesiologist, radiologist and pathologist. In this example, your referral must recognize that each of these provider types will be delivering care and ensure that our beneficiary is serviced by network providers credentialled to provide only the highest quality care while also representing one component of best value to the Government.

c) The definition of referral in Section H-8.l appears to exclude hospital-based providers since no appointment is offered for these providers. Is this correct?

Response: No.

d) Should the contractor calculate the percentage of total cost for a hospitalization that is rendered by non-network hospital-based providers to determine the proportion of the referral to hospital that is non-network?

Response: No. The calculation should follow the example provided above. In the example, the contractor referred the beneficiary to six different providers. If the radiologist in this example is non-network and the remaining 5 providers are network, the contractor will have achieved compliance with the requirement 83% of the time.

e) A hospitalization may involve 3 to 6 or more hospital based providers, potentially creating multiple referrals from one act of directing the beneficiary to a ... provider. Counting the services of hospital based providers as separate referrals appears to be inconsistent with the counting of outpatient referrals, like mixing apples with oranges. Would the government consider removing services by hospital based providers from RFP Section 7.3.2 and addressing this issue separately?

Response: No.

897. In past procurements, there has been at least a 30-day window following all questions being answered and all amendments being issued before proposals are due. Will this be true in this procurement?

Response: The proposal due date is specified in the solicitation, as revised by amendment. This date is not tied to answers to questions, nor to date of amendments. Potential offerors are cautioned against making assumptions based on other procurements.

898. The Congress, in Public Law 107-203 (See 42 USC, Sec. 1395y(a)(22)), required Medicare providers to submit all claims electronically as of October 16, 2003. The law, however, allows providers to apply for an exception to the requirement when there is no method available to submit electronically or when the provider qualifies as a "small provider of services or supplier", as defined in the law (generally a provider with less than 25 or less than 10 employees, depending on the specific situation). In light of the fact that the Congress has directed that the TRICARE program mirror the Medicare program in many other material ways, we have these questions regarding the Medicare provision and the RFP requirements that all TRICARE network providers and all high volume non-network providers must submit all claims electronically. (Reference C 7.1.10)

A. Do the exceptions provided in 42 USC, Sec. 1395y(h)(1)(A) apply to TRICARE providers otherwise required to submit electronically (e.g., if there is no method available for electronic submission or if the entity qualifies as a "small provider of services or supplier.")?

Response: No. The TRICARE requirement is for network providers which do not exist in Medicare indemnity programs.

B. Will exceptions granted by the Secretary of Health and Human Services for the Medicare program apply to TRICARE?

Response: No

C. If the Government will not recognize the Medicare exceptions, will the Government define its own allowable exceptions for TRICARE, as Medicare has done?

Response: Yes, Section C-7.1.10 states that an exemption may be granted when it is in the best interest of the Government.

D. For urgent/emergent reporting, when does the 24 hour period begin (e.g., at ER triage, MD assessment, patient stabilization, decision to admit, or some other point)?

Response: The reporting begins with the physician assessment.

899. The Managed Care Support contractor is responsible for the network that serves Medicare eligible TRICARE beneficiaries, but has no input into claims processing or specific claims resolution processes for providers in relation to this population. Will the Government incorporate specific interface requirements into the TDEFI contract to permit MCS contractors to help resolve any issues their network providers may have with the TDEFIC? (Reference C 7.1.3)

Response: We are unclear as to what exactly you are asking. Any claims issues should be resolved between the provider and the TDEFI contractor. Please provide examples.

900. The Operations Manual, Chapter 5, Section 1, 2.1. states that the contractor cannot finalize provider contracts without input from MTF commanders and the Regional Director. 2.0. of the same section requires the contractor to offer existing network providers the opportunity to participate in the contractor's network (Reference C 7.1.3). We have the following questions about these requirements:

A. Does 2.1 imply that the contractor cannot finalize any contracts before obtaining MTF and Regional Director input, or that the contractor cannot finalize the network (I.e., network sizing/close the network concept) before obtaining that input?

Response: The intent is that the contractor shall receive the Regional Director and MTF Commanders input as required by the MOU requirements of the TOM, Chapter 16, Section 1 prior to finalizing the network in each MTF catchment area and BRAC sites. The contractor may finalize any individual provider contract but the final make-up is not established until the required input is received. A future manual change will clarify this paragraph

B. If 2.1. prevents the contractor from finalizing individual contracts, does that make sense in the context of 2.0., which states that the contractor must offer a contract to all existing network providers anyway?

Response: See above. The intent is to offeror existing network members an opportunity to continue their TRICARE relationship as a network provider and is not intended to delay development of the network.